

government-owned. This use allowance shall use the principles established in Section H. above.

IV. Standards

- A. In accordance with Chapter 120, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.
- B. Reimbursement rates shall be established prospectively for each individual provider based on the most recent historic costs, but historic costs shall be limited to allowable percentage increases from period to period, as described in L. below. Further, if certain costs are determined by the AHCA Office of Medicaid or the AHCA Office of Audit Services, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1 and this Plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.
- C. Prospective payment rates shall be established semi-annually on April 1 and October 1. The most current acceptable cost report received by the agency by February 1 and August 1 shall be used in the rate-setting process to set rates effective on April 1 and October 1, respectively. The rate-setting process is detailed in Section V of this plan. The same cost reports used for the April 1, 1998 rate semester or the most current cost report received by August 1, 1998 by the agency shall be used to establish rates effective October 1, 1998 through March 31, 1999.
- D. Reimbursement rates shall be calculated separately for two classes. The classes shall be based on the four levels of ICF/MR-DD care as defined in Chapter 59G-4.170 F.A.C. The four levels of care, listed in ascending order of handicap severity, are Developmental Residential, Developmental Institutional, Developmental Non-ambulatory, and Developmental Medical. Developmental

Residential and Developmental Institutional shall constitute one class for reimbursement purposes, while Developmental Non-ambulatory and Developmental Medical shall constitute the other. All providers must allocate costs by the four levels of care in their cost reports. The agency shall monitor placements of clients to determine whether discrimination against clients with higher cost or more complex service needs is occurring. If the agency determines that such placement discrimination is occurring, this plan may be amended to provide for payments based on four levels of care.

- E. For the two classes described in D. above, four components of the total reimbursement rate shall be calculated separately. These four components are operating costs, resident care costs, property costs, and return on equity costs or use allowance, if applicable. Inflation allowances used in the rate-setting process shall be applied to the operating and resident care cost components independently for the two reimbursement classes.
- F. The prospectively-determined individual provider's rates shall be adjusted retroactively to the effective date of the affected rates under the following circumstances:
 - 1. An error was made by AHCA in the calculation of the provider's rates.
 - 2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would effect a change of 1 percent or more in the total reimbursement rate. The amended cost report must be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 60 days after the exit conference between field audit staff and the provider has been completed.
 - 3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.

- G. The following provisions apply to interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process described in Section V, as well as to changes in a provider's allowable cost basis. These provisions are not applicable to new providers' first year interim rates, which are addressed in sections H. and I. below.
1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of 1 percent or more in the provider's total per diem reimbursement rate.
 2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (1) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least \$5000 and would cause a change of 1.0 percent or more in the provider's current total per diem rate. The provider must submit documentation showing that the changes made were necessary to meet existing state or federal requirements.
 3. In the event that new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require all affected providers to make changes that result in increased or decreased resident care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by the agency and shall be the basis for establishing reasonable cost parameters.

4. Vacancy interim rates will be prohibited unless the bed(s) in question has been empty for at least 90 days (the waiting period), the facility has an occupancy rate of at least 95 %, and the effected reimbursement rate is based upon patient days that included occupancy of the bed(s). The vacancy interim rate will not cover the 90-day waiting period.
5. Interim rate requests resulting from (1), (2), (3) and (4) above must be submitted within 60 days after the costs are incurred, and must be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously-established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request subsequent to June 30, 1984, the AHCA Office of Medicaid must determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid must approve or disapprove the interim rate within 60 days. If the Office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.
6. Interim Rate Settlement.

Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to

AHCA. Under-payment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider.

After the interim rate is settled, a provider's cost basis shall be restricted to the same limits as those of a new provider per Section I. below.

7. The right to request interim rates shall not be granted for fiscal periods that have ended.

- H.1. For a new provider in a facility with greater than six beds, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited as follows:

- A. Property Costs:

Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

- B. Operating Costs:

Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that currently have prospective rates.

- C. Resident Care Costs:

Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

- H.2. For a new provider in a facility with six beds or less, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited by ceilings as follows:

- A. Property Costs Ceiling:

Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

- B. Operating Costs Ceiling:

Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that currently have prospective rates.

C. Resident Care Costs Ceiling:

Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

D. Total costs per diem ceiling (including return on equity):

Shall not exceed \$ 239.09 for the Developmental Residential/Developmental Institutional classes and shall not exceed \$267.02 for the Developmental Non-Ambulatory classes as of April 1, 1998. For subsequent rate semesters, these ceiling amounts shall be inflated forward based on one times the ICF/MR-DD inflation index utilizing the same inflation methodology as used in calculating prospective rates. When a provider's interim cost is limited to the total cost ceiling, the ceiling shall be allocated to each component based on the percentage that each component's interim cost is to the total of all components' interim costs, including return on equity.

Example:	Interim Cost	Percent to total	Ceiling
Operating	58.15	23.26	55.82
Resident Care	158.89	63.56	152.54
Property	25.70	10.28	24.67
ROE	7.26	2.9	6.97
Total	250	100%	240

- I.1. For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12- month period submitted by the

provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Medicaid .

- I.2. For a new provider in a facility with six beds or less, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12- month period submitted by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item subject to base year ceilings in Section V.B. of this plan shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs subject to base year ceilings in Section V.B. of this plan shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at the lesser of 100 percent of the total allowable costs or the ceilings as determined by Medicaid .
- J. Incentives for rates paid on and after October 1, 1998, shall be paid to providers whose annual rates of cost increase for operating costs or resident care costs from one cost reporting period to the next are less than 1.4 times the average cost increase for the applicable period documented by the ICF/MR-DD Cost Inflation Index used in this plan. Calculation of incentives shall be as detailed in Section V.A.7. of this plan.
 1. To encourage high-quality care while containing costs, incentive payments shall be paid to those facilities which are not out of compliance with any Condition of Participation. Cost containment operating and resident care incentives shall be prorated for the percentage of days that a provider is out of

compliance with any Condition of Participation during the rate semester in effect one year prior to the rate semester being set.

K. A provider's reimbursement for service provided under the Florida Medicaid Program shall be the lower of: the provider's usual and customary charges to the general public for such services, except for public facilities rendering such services free of charge or at a nominal charge, that is, less than or equal to 50 percent of costs; or the rates established for the provider under this reimbursement plan.

L. The use of a target rate of inflation for cost increases shall be used as a measure of efficient operation for purposes of this reimbursement plan. The target rate of inflation principle is that a provider's operating and resident care per diems by reimbursement class should not increase from one fiscal period, that is, year, to the next by a percentage amount which exceeds 1.4 times the average percentage of increase in the Florida ICF/MR-DD Cost Inflation Index for the same period. If a provider's per diem costs for either reimbursement class for operating or resident care exceeds the target rate of inflation, then the allowable per diem costs of the period in which the excessive costs occurred shall be limited to a level equal to the prior period's allowable per diem costs inflated by the target rate percentage. Only allowable per diem costs shall be used for prospective rate setting purposes and for future target rate comparisons.

M. Aggregate test comparing Medicaid to Medicare according to 42 CFR 447.253(c)(2) , the Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, incentives shall be reduced or eliminated as necessary to meet the aggregate test.

N. Base Costs:

The initial base costs for each provider shall be the allowable costs documented by the cost report used to establish the rate being set. For new providers entering the Medicaid program the initial base costs shall be established in accordance with Section IV.I. of this plan. Prospective rates calculated using unaudited costs shall be retroactively adjusted when audit results become available.

V. Methodology

A. Prospective rate-setting method for rate semesters beginning on or after October 1, 1998.

1. For rate semesters beginning on April 1 of a given year, the prospective rates shall be set using the most current acceptable cost report on file with AHCA as of February 1 of that year. For rate semesters beginning on October 1 of a given year, the prospective rates will be set using the most current acceptable cost report on file with AHCA as of August 1 of that year. For the rate semester October 1, 1998 through March 31, 1999, the same cost reports used in setting April 1, 1998 rates or the most current cost report received by the agency by August 1, 1998 shall be used.
2. Review and adjust each provider's cost report referred to in Section IV.N. above to reflect the results of desk or on-site audits, if available.
3. Determine total allowable cost by reimbursement class for property cost, resident care cost, operating cost, and return on equity or use allowance if applicable. See the Definitions section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A. Costs for providers with six beds or less shall be allocated to each reimbursement class by the methodology shown in Appendix A-1.

4. Calculate per diems for each of the four cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.
5. Calculate the target rate of inflation factor representing the allowable increase in operating and resident care costs from the prior cost reporting period. The target rate of inflation factor is calculated by multiplying 1.4 times the simple average of the monthly Florida ICF/MR-DD Cost Inflation Indices associated with the more recent cost reporting period divided by the simple average of the monthly indices associated with the prior cost reporting period.
6. This step presumes that the cost components of the cost reporting period immediately prior to the current cost report have been adjusted for base year ceiling limitations, inflation target rate limits and incentives, and that they now represent the allowable base costs against which the current costs are to be evaluated. If the current year cost report includes new costs that were incurred in order to meet State or Federal rules, laws, regulations, or licensure and certification standards, and the provider did not request an interim rate adjustment for those costs during that cost reporting period or if the costs did not meet the \$5,000 and 1 percent threshold under the interim rate provisions in Section IV.G., then an adjustment shall be made to the current base year costs such that the calculation of the target cost appropriately accounts for cost incurred in meeting laws, rules, or regulations. For such an adjustment to be made, the provider must furnish adequate supporting documentation with the cost report. Multiply the adjusted base cost components for operating and resident care costs for each reimbursement class by the target rate factor computed in Step 5 above to reflect the allowable change in costs. For the October 1, 1998